



Annapolis Fire Department

Operating Policy Manual

Chapter 7: Operations

7.23 Patient Care, Response, Transportation and Transfer

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Approved by: _____


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7.23.1

Patient Care

Patient care shall be governed by the current edition of “The Maryland Medical Protocols for Emergency Medical Services Providers,” published by the Maryland Institute for Emergency Medical Services Systems (MIEMSS). Additional procedures, techniques and options may also be mandated by the Local Jurisdictional Medical Director at their discretion.

7.23.2

Patient Transportation

- A. The Annapolis Fire Department provides emergency and non-emergency transport from the scene to the closest appropriate healthcare facility.
- B. The “Region III Alert Status System” document shall serve as a guide for bypassing the closest facility. Specialty referral patients should be transported to the appropriate specialty referral center via MSP Helicopter or via a ground unit as the situation dictates, and as governed by “The Maryland Medical Protocols for Emergency Medical Services Providers”.
- C. Requests for routine and/or scheduled appointments will generally not be handled. If a provider is in doubt about whether to transport a patient, they may contact the EMS Supervisor for direction, provided this can be done in a timely manner. When in doubt, a provider should transport the patient and notify the EMS Supervisor (via either email or a special report) after the call if that provider felt the transportation was inappropriate or represented abuse of the service. Providers must maintain the utmost courtesy and professionalism during these types of incidents.

7.23.3

Ambulance Operation and Priority Response of Medical Units

7.23.3.1

Patient Care

- A. At any time that a patient is in the ambulance, a minimum of one (1) medically trained attendant shall be with the patient in the patient area of the ambulance and available for immediate service to the patient.
- B. It is important that the patient be extended every courtesy. Providers shall remain professional and courteous even if a patient is unruly and uncooperative.
- C. Every patient transported in a City ambulance shall be properly secured to the stretcher with over the shoulder straps utilized unless seated. All patients who are not transported on the stretcher and any passengers in the ambulance shall have seat belts fastened. Only during an extreme case or under physician's order shall a provider be prevented from securing a passenger properly.
- D. All providers shall remain seated and secured with seatbelts unless administration of a required patient intervention necessitates removing the provider's restraints.

7.23.3.2

Transport Priority Definitions

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- A. Priority I - Situations that involve critically ill or injured persons with life threatening injuries or life threatening medical needs that need immediate attention. Delay in treatment may be harmful to the patient (potentially threatens life or function). The speed of response shall be "reasonable for conditions" and the operator shall have the vehicle "under control" at all times. All warning devices will be in full use at all times.
 - B. Priority II - Situations that involve less serious conditions, requiring emergency medical attention but not immediately endangering the patient's life. The operator shall have the vehicle "under control" at all times and speed of response shall be "reasonable for conditions". All warning devices will be in full use at all times.
 - C. Priority III - Non-urgent conditions, requiring medical attention but not on an emergency basis. The speed of response will be no greater than the posted speed limit and comply with all applicable vehicular laws.

7.23.4

Security and Handling of Patient Valuables

- A. There are times during the provision of patient care when it is necessary to move or remove a patient's clothes and/or belongings. If the patient is alert, have them secure their own valuables. If the patient is unconscious or otherwise unable to remove/secure their belongings, the treating personnel shall do so as necessary or, when possible, request that an on-scene police officer secure them.
- B. After patient care has been transferred to the hospital, any personal effects should be given to the receiving nurse or other hospital representative (i.e., security guard). Document in the patient's narrative what belongings were turned over and to whom. In the event that it is necessary to open a patient's wallet or purse, make every attempt to have a police officer or other reliable bystander witness this.
- C. All weapons will be handled and secured by law enforcement personnel.

7.23.5

Unit Keys

Anytime a unit is at the hospital it is to be secured and the keys shall be removed from the unit.

7.23.6

Transportation of Service Animals (Dogs)

Maryland Law and the American with Disabilities Act (ADA) requires hospitals and first responders to modify their practices as necessary to ensure that the service dog users are provided with the same assistance as their peers. This requires that EMS providers must be prepared to transport safely service dogs with their handlers in ambulances. It must be clear that Maryland Law and ADA requirements are not suggestions for you to decide to comply with or not, they are legally binding and must be included in your overall treatment plan.

Maryland's service animal law and ADA applies to guide dogs, signal dogs and other animals that are individually trained to perform tasks for people with disabilities such as pulling a wheelchair, alerting upon the onset of a seizure, picking up dropped items, alerting to certain sounds, guiding someone who is visually impaired or providing minimal protection of rescue work.

Examples of service animals that must be allowed into public accommodations under the Maryland Law and ADA include:

- A. Hearing Dogs – which alert their handlers to important sounds, such as alarms, doorbells and other signals.
- B. Guide Dogs – which help those who are blind or visually impaired to navigate safely.
- C. Psychiatric Service Animals – which help their handlers manage mental and emotional disabilities for example; interrupting self-harming behaviors, reminding handlers to take medication, checking spaces for intruders or providing calming pressure during anxiety or panic attacks.
- D. Seizure Alert Animals – which let their handlers know of impending seizures and may also guard their handlers during seizure activity.

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- E. Allergen Alert Animals – which let their handlers know of foods or other substances that could be dangerous, such as peanuts.
- F. Emotional Support Animals
1. Maryland Law and the ADA do not cover what is commonly referred to as “emotional support animals”, which are animals whose presence provides a sense of safety, companionship and comfort to those with psychiatric or emotional conditions. Although these animals often have therapeutic benefits, they are not individually trained to perform specific tasks for people with disabilities. Since they have not been trained to perform a specific job or task, they therefore do not qualify as service animals under Maryland Law and the ADA.
 2. There is no Maryland Law or ADA legal obligation to allow emotional support dogs to accompany a patient in the ambulance. However, best practice is to accommodate an emotional support dog based on the overall situation and available options. When considering the emotional support animal’s role during patient transport (i.e., any animal that doesn’t fit the Maryland Law and ADA definition of a service dog), it is certainly legal to deny transport of the animal, but consider if this is the best overall option for the patient.
- G. Under Maryland Law and ADA Guidelines there are three (3) key provisions for EMS providers to be aware of:
1. Beginning on March 15, 2011, only dogs are recognized as service animals.
 2. The Maryland Law and ADA define a service animal as “any dog that is individually trained to do work or perform tasks for the benefit of an individual with a disability, including; physical, sensory, psychiatric, intellectual or other mental disability.
 3. Generally, EMS providers must permit service animals to accompany people with disabilities in all areas where members of the general public are allowed to go.
- H. The Maryland Law and ADA significantly limit the questions that EMS providers may ask to determine if a dog is a service animal. In situations where it is not obvious that the dog is a service animal, EMS providers may only ask:
1. Is the dog a service animal required because of disability?
 2. What work has the dog been trained to perform?
 3. Providers CANNOT ask about the person’s disability, or ask that the dog demonstrate its ability to perform the work or task. They also CANNOT ask for or require documentation, such as proof that a service animal has been certified, trained or licensed as a service animal. It is also not necessary that the dog wear a vest, ID Tag or anything else to identify it as a service animal. It should also be noted that allergies and fear of dogs are not valid reasons for denying access or refusing service to people using service animals.
- I. Providers may refuse to transport a service dog for any one of three primary reasons listed below. The Maryland Law and ADA do not specifically define who is responsible for the service dog should it not be transported, but the Annapolis Fire Department policy is that we will work with law enforcement to arrange for transportation (private car transport with family, friends, law enforcement, etc.) and make every effort to reunite the dog with the patient as soon as reasonably possible.
1. If the service dog will fundamentally alter the provider(s) ability to provide lifesaving care.
 2. If the dog is out of control and the handler does not take effective action to control the animal.
 - a. The patient is required to maintain control of the dog at all times. This means that the service dog must be harnessed, leashed or tethered, unless these devices interfere with the service animal’s work or the individual’s disability prevents using these devices. In that case, the individual must maintain control of the animal through voice, signal or other effective controls.
 3. If the dog is not housebroken.

J. Best Practices for Safely Transporting Service Dogs

1. There is no regulation to specify where a service dog should be placed during transport. The size of the dog, condition of the patient, assistance from the patient's family/friends and space configurations of the ambulance will drive this decision. For everyone's safety, the dog should be tethered to a stationary device, the stretcher or a seatbelt that is locked into place
2. Be sure to secure the stretcher before placing the dog into the patient compartment. Remove the dog first upon arrival at your destination.
3. If the dog collar is a choke collar (chain), place the leash on the appropriate collar ring to prevent injury or asphyxiation when securing the dog.
4. Cover sharp surfaces on perforated running boards and rear steps to prevent lacerations to the dog's paws.

K. Refusal to transport service animals.

1. Any time a provider(s) decides to deny transport of the service animal, two distinct issues could result.
 - a. The patient's emotional well-being may suffer and will likely result in additional anxiety.
 - a. Refusing a legitimate disability accommodation could have legal repercussions, including claims of unlawful discrimination.
2. If possible, the decision to deny transport of a service animal should be made in consultation with an EMS supervisor taking into account the possible impact of the decision on the patient's needs and the public's negative perception of the decision.
3. All refusals to transport a service animal must be supported in the EMS report and further documented by a Special Incident report addressed to the Fire Chief.

7.23.7

Bariatric Unit Response Guide

Medic 37 is a Bariatric Response Unit. The unit is equipped with a MacLift platform that will assist in the transportation of bariatric patients. The response of this unit will be determined by Fire Alarm or personnel on the scene who determine that this unit may assist in the transportation of a patient.

7.23.7.1

For calls within the City Limits or with an Annapolis Fire Department Medic Unit on the Call.

- A. Fire Alarm may dispatch the Bariatric Unit upon request. If an AFD Medic Unit is on the call and there is a need for the Bariatric Unit, the units on location should contact the EMS Duty Officer. The EMS Duty Officer will make the decision as to who will pick up the Bariatric Unit. The possible scenarios follow:
 1. If a crew is in the station, they will take the Bariatric Unit to the scene of the call and bring the Medic Unit on the scene back to Eastport.
 2. If there is no crew at the station, the EMS Duty Officer will respond to the station and take MU37 to the scene.
 3. If the EMS Duty Officer cannot respond, another unit may respond to the station and pick up MU37 to respond to the scene.
- B. Medic 37 shall then be added to the incident and all Status Messages must be depressed as with any other incident. Personnel shall assure that the bariatric stretcher is located within the unit prior to deployment.
- C. Medic 37 will be housed at the Eastport Station Storage Building. A Knox Box is on the building for easy access to the unit. A key to the Storage Building will also be located in the Station Officers' office at the Eastport Station. If feasible, the crew from the Eastport Station shall be notified that the unit is being deployed.

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- D. A training program is located in PowerDMS; all personnel shall be familiar with the proper operation of the lift and equipment assigned to Medic 37.
 - E. Medic 37 preventative maintenance checks will be conducted by the crews at the Eastport Station.

7.23.7.2

For Bariatric Unit Mutual Aid Calls in all other jurisdictions.

- A. There will always be two (2) personnel to take MU37 to calls in other jurisdictions.
- B. The crew on MU37 is there for assistance, the continuity of care for the patient is paramount and the crew already caring for the patient should continue the patient care, if possible.
- C. There will be a few instances in which the crew caring for the patient must hand over care to the MU37 crew. When that occurs, the MU37 crew should notify the EMS Duty Officer following transfer of patient care to the hospital.
- D. Patient Care Reports (PCRs) must be completed and contain patient information and any actions performed by AFD crews. These reports should not be marked as “operational support” only.

7.23.8

Transfer of Care

7.23.8.1

Purposes

This policy is to establish standards for patient care transfer from City of Annapolis ambulances to Emergency Department staff. The secondary purpose of this directive is to provide both transparency and clear direction to the EMS clinicians and supervisors that may be confronted with challenging decisions during time of high EMS demand and limited receiving facility bed availability. This is essential because patient transfer delays pose a significant risk to our citizens and visitors due to the potential for limited resources available to respond to community needs.

7.23.8.2

Policy

The performance expectation for hospitals and free-standing medical facilities that are designated by MIEMSS to receive patients is to facilitate patient care transfer in less than twenty (20) minutes. At no time should this process be confrontational or adversarial, but a coordinated and collaborative transition from EMS to receiving facility staff.

7.23.8.3

Authority

Pursuant to the Emergency Medical Treatment and Labor Act, as defined in § 42 CFR 489.24(b), a person is considered a patient once they arrive on hospital property and is therefore the responsibility of the receiving emergency department.

7.23.8.4

EMS Clinician Responsibilities

- A. EMS Clinicians will make every effort to notify the receiving facility, via radio of their estimated time of arrival and patient condition. This should routinely be done in accordance with Maryland Medical Protocols concerning free-standing medical facilities.
 - 1. Extra notification effort should be made if clinicians have prior knowledge that a facility is on an alert status but they choose to take the patient there anyway. (Ex: an emergency department is on yellow alert but the EMS crew is transporting a Priority 1 patient.)
- B. Our general policy, subject only to the exceptions listed below, is to complete patient handoff within twenty (20) minutes of arrival at the emergency department (ED) after the patient has been triaged by the ED staff.

“Patient handoff” shall consist of:

1. Moving the patient from the ambulance stretcher to an acceptable location.
 2. Completion of a MIEMSS-approved “short form” or electronic patient care report.
 3. A verbal report to an emergency department nurse or doctor, that describes: the location and general condition of the patient, and any treatments or interventions performed.
- C. If the receiving facility staff are unable to assume patient responsibility within twenty (20) minutes, they may request that EMS clinicians remain with the patient for a longer period of time. Note that this is a request and not a demand. This time period shall be known as “extended ambulance wait time.”
- D. Upon receipt of such a request by the hospital for an extended ambulance wait time, EMS clinicians will consider the request in light of the following factors:
1. The current condition of the patient.
 2. The capability of the EMS crew to furnish any required treatments or interventions.
 3. The availability of other City of Annapolis medical units to cover any additional emergency calls in the service area.
 4. Any other pending calls that may require a response from this EMS crew.
 5. Input or direction from on-duty EMS Supervisors or the shift Battalion Chief.
 - a. EMS Crews that remain with a patient in the emergency department for longer than thirty (30) minutes should place the facility on “re-route”, in accordance with Region III policy AND notify the on-duty EMS Supervisor.
 - b. They must also complete the pertinent data fields in the “Call Delays” section of the PCR.
- E. In the following circumstances, regardless of whether or not a request for an extended ambulance wait time is made by the receiving facility, EMS crews shall remain with the patient and provide appropriate care, in accordance with Maryland Medical Protocols. Care in these instances shall continue as long as the patient’s condition persists or until relieved by a hospital clinical provider. EMS clinicians shall adhere to their scope of practice and applicable Maryland Medical Protocols.
1. Any patient in cardiac or respiratory arrest that is undergoing active resuscitative efforts.
 2. Any patient who is an active threat to themselves or others and where withdrawal of trained monitoring could pose a risk. This includes patients with any cognitive deficit.
 3. Any patient in active labor.
 4. EMS Crews that remain with a patient in the emergency department for longer than thirty (30) minutes should in accordance with Region III policy place the facility on “re-route”, notify the on-duty EMS Supervisor and they must also complete the pertinent data fields in the “Call Delays” section of the PCR.
- F. In cases where the EMS crew determines that the patient does not require continued clinical care or monitoring from the EMS crew and the facility is unable or unwilling to physically assume care of the patient, the EMS crew may transfer the patient to a hospital bed, if available.
1. If no bed is available, the EMS crew may place the patient in the ED waiting room, on a chair in a hallway, or on an available portable cot or similar device as long as it is clinically appropriate - refer to the Direct to Triage protocol for more specific guidance.
 2. The above actions require the authorization of an EMS Supervisor. Additionally, clinicians must:

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- a. Thoroughly document the pertinent details in the PCR narrative.
 - b. Complete any additional Department mandated tracking forms.
- G. EMS Clinicians shall use their best efforts to obtain a receiving facility signature, whether in a medical or an administrative capacity. If no hospital representative is available and/or willing to sign, EMS clinicians should document the same in the signature field of the PCR and provide a detailed description of the event in the PCR narrative.

7.23.8.5

Receiving Hospital Expectations

Our ultimate goal is to ensure appropriate patient care while balancing the operational needs of the department, being mindful of our readiness responsibility to the citizens and visitors to the City of Annapolis. We value our collaborative relationship with our receiving facilities and EMS personnel shall act with professionalism and courtesy at all times.

- A. The hospital's responsibility for the care of a patient begins when the patient or ambulance arrives on hospital grounds and requires an initial assessment and triage of the patient without delay.
- B. Emergency department staff will work with EMS clinicians and/or EMS supervisors to assure optimal patient care turnover time and resolve any instances of delayed and/or extended wait times as soon as practical.
- C. During periods of an unusual level of demand, hospitals should activate internal protocols for emergency department saturation using pre-determined mechanisms.
- D. The EMS supervisor and/or the Battalion Chief of EMS/Safety will work with facility staff to ensure pre-established policies are being utilized to prioritize patients arriving by EMS ambulances and effectively manage ambulance offload delays. This may include an escalation of communication in the following order:
 - 1. Hospital ED manager.
 - 2. Hospital bed coordinator.
 - 3. On-call hospital administrator.
- E. As per MIEMSS, a unit may place any facility within Region III on Reroute, and our policy is that this shall be communicated through Fire Alarm.
- F. The EMS Duty Officers shall monitor all Reroute situations and make notifications to the On-Duty Battalion Chief as appropriate.
- G. Related Phone Contacts:
 - 1. EMS36 443-871-5791
 - 2. EMS1 443-336-3300
 - 3. EMS2 240-459-9241
 - 4. EMS3 240-459-5058
 - 5. EMS4 443-336-8154
 - 6. AAMC
 - a. Hot Line 410-222-4300
 - b. Charge Nurse 443-481-1191

c.	Door Code	8888
7.	BWMC	
a.	Hot Line	410-222-6850
b.	Charge Nurse	410-787-4567
c.	Door Code	2222